Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155839	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER: Summit Health and Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 701 S Main St Summitville, IN 46070	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45122 Based on interview and record review, the facility failed to ensure the resident's advance directives were completed by the resident with decisional capacity for 1 of 16 residents reviewed for advance directives. (Resident 4) Finding includes: Resident 4's clinical record was reviewed on [DATE] at 9:04 a.m. Diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris (thickening and hardening of the artery without chest pain) and paroxysmal atrial fibrillation (irregular heartbeat that lasts a short time and usually returns to normal). Current physician's orders included no CPR (cardiopulmonary resuscitation), dated [DATE]. An Indiana Physician Orders for Scope of Treatment (POST) form was completed on [DATE]. In the instructions, the form indicated if the patient lacked decisional capacity, the legal representative or a proxy may complete the POST on behalf of the patient. Section E indicated in order for the POST form to be effective the patient, legally appointed representative, or proxy must sign and date the form. The resident representative had signed the form on [DATE]. Section F indicated the relationship of the representative or proxy identified in Section E and indicated if the patient does not have capacity. The form was signed by the nurse practitioner on [DATE]. An admission Minimum Data Set (MDS) assessment completed on [DATE] indicated the resident was cognitively intact. A care plan, initiated on [DATE] and revised on [DATE], indicated the resident was a no code (do not resuscitate) per her desire. A Social Service progress note, dated [DATE] at 12:09 p.m., indicated the resident was her own responsible person. During an interview, on [DATE] at 2:14 p.m., RN 3 and LPN 4 indicated the nurses went over advance directives with the residents or their representatives on admission. If a resident was mentally competent, he/she should sign the advance directives. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 2:16 p.m., QMA (qualified medication aide) 5 indicated the resident was alert and oriented. During an interview, on [DATE] at 2:22 p.m., LPN 6 indicated the resident knew the staff by name and seemed oriented. If a resident was oriented, then advance directives would be signed by the resident. She thought the resident had wanted her representative to sign the advance directives. During an interview, on [DATE] at 3:09 p.m., the DON indicated the resident's daughter had signed the POST as the resident had refused to sign her admission paperwork. The daughter had signed everything. She was uncertain if the resident had been reapproached to sign advance directives or if the resident's record contained documentation of the resident's refusal to sign paperwork. During an interview, on [DATE] at 3:55 p.m., the DON had been unable to locate the resident's refusal to sign paperwork during the admission process or attempts to reapproach the resident later. She provided a statement signed by the Office Manager on [DATE] that indicated the resident refused to sign paperwork on her own and insisted the representative sign for her due to not being in a well enough state. During an interview, on [DATE] at 4:52 p.m., the Administrator indicated she had been unable to locate the facility policy on advance directives. She had reached out to her corporate consultant and was still waiting for the policy. 3XXX,d+[DATE](f)(7)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45122 Based on observation, record review, and interview, the facility failed to ensure a resident was not started on a routine antipsychotic medication without indication for 1 of 5 residents reviewed for dementia care (Resident 82). Finding includes: During an observation, on 9/4/24 at 11:00, Resident 82 sat in a wheelchair in his room while his representative shaved him. He kept his eyes closed throughout the procedure and had to be roused for questions. During an observation, on 9/5/24 at 1:18 p.m., the resident sat outside the facility in a wheelchair with a visitor sitting at his side. During an observation, on 9/9/24 at 8:34 a.m., the resident sat in a wheelchair in his room and spoke about his wife. During an observation, on 9/9/24 at 1:54 p.m., the resident propelled himself in a wheelchair down the hallway using the siderails to pull himself and smiled as other residents, staff, and visitors talked to him. Resident 82's clinical record was reviewed on 9/6/24 at 8:23 a.m. He was admitted on [DATE]. Diagnoses included Alzheimer's disease, dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance, and unspecified symptoms and signs involving cognitive functions and awareness. Current physician's orders included donepezil (for Alzheimer's disease) 10 mg daily, memantine (for Alzheimer's disease) 10 mg daily, and quetiapine (antipsychotic) 50 mg daily at bedtime. An admission Minimum Data Set (MDS) assessment completed on 8/19/24 indicated the resident was severely cognitively impaired. He exhibited physical symptoms not directed toward others for one to three days during the assessment period. The symptoms did not significantly interfere with the resident's care and did not put others at significant risk of physical injury. He did not exhibit wandering or rejection of care behaviors. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current care plan, initiated on 8/20/24 and revised on 8/26/24, indicated the resident had a behavior problem related to: He refused care, yelled, threatened staff, and wanted to find wife. His cognitive ability was worse in the evening and night where he became more confused and acted out. His interventions included the following: Administer medications as ordered. Monitor/document for side effect and effectiveness (8/20/24); Caregivers to provide opportunity for positive interaction and attention. Stop and talk with the resident as passing by (8/20/24); Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert his attention. Remove the resident from the situation and take to an alternate location as needed (8/20/24); Minimize potential for the resident's disruptive behaviors by offering tasks which divert attention such as a busy box, snack, or talking about his family (8/20/24) and Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes (8/20/24). A Nurses Note, dated 8/15/24 at 2:00 a.m., indicated the resident yelled out repeatedly. He wanted to know where he was, where his wife was, and what happened to his leg. His questions were answered. He was given reassurance. Five minutes later, the resident continued to yell and awakened others. The resident exhibited the yelling behavior several times. A Nurses Note, dated 8/22/24 at 3:17 a.m., indicated the resident yelled out and demanded to go home. The resident threatened staff with physical harm. His confusion triggered the behavior. The resident was clean and dry with no sign or symptoms of distress. He was agitated. Interventions attempted included the following: Fluids and snacks were offered; Assistance to the wheelchair to sit up for a while was offered; and Assistance to turn on and watch television was offered. The interventions were refused. The resident was reminded he was at the facility for therapy, and it was the middle of the night. The resident indicated he did not care. The resident was given incontinence care and was quiet. A Nurse Note, dated 8/23/24 at 6:17 a.m., indicated the resident yelled out most of the night wanting to know where his wife was, why he was at the facility and where his leg was. Staff attempted to redirect and were not very successful. His confusion and dementia triggered the behavior. The staff assisted the resident up into his wheelchair. He sat at the nurses' station, was given a snack, and interacted with the staff. The resident began to fall asleep and was assisted back to his bed. The resident slept for about an hour and a half and began to yell out again. A Nurse Note, dated 8/26/24 at 11:59 p.m., indicated the resident yelled out and wanted the police called. The resident indicated he was at his home. The resident was reminded he was at the nursing home. He wanted the police called and wanted his wife to be with him. Staff reminded him of his location, situation, time of night and that his wife had been there earlier and was currently sleeping. He did not accept the staff's reminders. A Nurse Note, dated 8/27/24 at 12:07 a.m., indicated the triggers for the above behaviors was the resident saw or heard staff pass by his room. He indicated it was too noisy. He was confused and unaware of the situation, location, time, and date. Reassurance was not effective. He became argumentative and agitated. The resident was reminded of the location and his situation. He was offered food and fluids. The staff attempted to reposition him in bed. The television was turned off. A light at bedside was turned on. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurses Note, dated 8/27/24 at 11:05 a.m., indicated the resident's representative had spoken to the resident's neurologist about the resident's yelling and behaviors at night. A prescription was sent for quetiapine 50 mg daily at bedtime related to moderate dementia with behavioral disturbance. The Nurse Practitioner (NP) was updated. The resident's representative brought the medication to the facility. The physician's orders lacked orders for psychoactive medications upon admission and prior to the initiation of the quetiapine order. A Nurses Note, dated 8/31/24 at 1:16 p.m., indicated the resident's representative reported the resident had been having increased evening and daytime sleepiness the last few days. The resident had napped on and off throughout the shift but was easily awakened. A Nurse Note, date 9/2/24 at 11:03 p.m., indicated the resident had started quetiapine and it was not effective. He yelled out, argued with staff, and wanted the police called. During an interview, on 9/9/24 at 1:58 p.m., CNA 10 indicated the resident had urinated on the floor today. He had yelled out for assistance after he urinated on the floor. She had not been told any special interventions for the resident for any behaviors. During an interview, on 9/9/24 at 2:02 p.m., CNA 9 indicated the resident liked to call out. His behaviors got worse after supper when his wife left because he was sundowning (his confusion increased late in the afternoon into the night). The staff gave the resident snacks, took him to the bathroom often, because he liked to use the bathroom a lot and that helped a little. He also enjoyed talking to other residents. She thought the resident was lonely at times. During an interview, on 9/9/24 at 2:09 p.m., CNA 11 indicated the resident became anxious at night when his wife was gone. He tried to redirect the resident by talking about his wife. Later in the night, he got worse. Usually, the staff could talk to him and give him ice cream and that helped. For the most part, he was sweet. During an interview, on 9/9/24 at 2:17 p.m., QMA 5 indicated she met the resident in the moment for his behaviors and that seemed to work. During an interview, on 9/9/24 at 2:18 p.m., LPN 6 indicated the staff had to get the resident out of bed sometimes. The resident believed the facility was his house and often asked why the staff were in his house. Sometimes he would sleep for several hours in bed. She thought the resident's representative had reached out to the resident's dementia doctor. She had attempted to call the resident's representative, but the resident's representative did not answer her calls, so she called another member of the resident's family. That was when the resident's representative contacted the resident's neurologist. She was uncertain if the facility had contacted the neurologist to discuss the resident's recent order for quetiapine. During an interview, on 9/9/24 at 3:04 p.m., the DON indicated she had not spoken with the neurologist or his office. The facility did not typically start with antipsychotic medication for behaviors. They worked with the doctor and the psychological services NP. She knew the resident was having behaviors. The resident's representative had called the neurologist and already had the bottle of the medication when she told the facility. The NP had been notified, and had said it was okay. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A description of the interactions between the neurologist's office and the resident's representative from the neurologist's office, provided by the Administrator on 9/9/24 at 4:20 p.m., indicated the neurologist had been contacted by the resident's representative on 8/26/24 at 8:49 a.m. The resident's representative indicated the resident was residing at the facility for rehabilitation and physical therapy. He had been in the hospital for a week for Respiratory Syncytial Virus (RSV) and a urinary tract infection. He was getting worse. His sundowning had worsened. He was not sleeping at night. The neurologist ordered quetiapine 50 mg daily at bedtime on 8/26/24 at 9:41 a.m. The resident representative was notified, on 8/26/24 at 9:50 a.m., of the new order and requested the order to be sent to a nearby pharmacy. An NP progress note, dated 8/27/24, provided by the Administrator on 9/9/24 at 4:20 p.m., indicated the resident had been seen for an admission follow up. He had been sundowning and at night, had not been sleeping well, and had become agitated. The resident's representative had reached out to the resident's neurologist. The resident had a history of dementia now with increasing behavioral disturbance. The neurologist prescribed the resident quetiapine 50 mg at bedtime to help with the insomnia and behaviors. Otherwise, the resident had been adjusting better during the daytime hours. A facility policy, dated 10/2022, provided by the Administrator on 9/9/24 at 4:20 p.m., titled Psychotropic Medication Policy, indicated the following: .Based on a comprehensive assessment of a resident, the facility must ensure: Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record . Facility will use extreme caution in utilizing antipsychotic medications in the elderly. The following will be considered prior to initiation of antipsychotic medication. 1. Behavioral symptoms present a danger to the resident or others. 2. Expression or indications of distress that are significant distress to the resident. 3. If not clinically contraindicated, multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress 3.1-37(a) 4.1-48(b)(1)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49411 Based on interview and record review, facility failed to ensure residents received offered vaccinations available for 1 of 5 residents reviewed for immunizations (Resident 8). Findings include: Resident 8's clinical record was reviewed on 9/6/24 at 9:24 a.m. Diagnoses included dementia without behavioral disturbance, psychotic disturbance, anxiety, post- traumatic stress disorder, major depressive disorder and pneumonia. Resident 8 had received pneumococcal polysaccharide vaccine (PPSV) 23 on 7/12/16, and pneumococcal conjugate vaccine (PCV) 13 on 7/16/15. CDC recommendations indicated to give one dose of PCV 20 at least 5 years after the last pneumococcal vaccine dose. Resident 8 was educated on PCV 20 and consented for the vaccine on 5/18/24. A written interdisciplinary team (IDT) note on the vaccination consent form, dated 5/19/24, received from the DON on 9/9/24 at 10:00 a.m., indicated the resident was currently ill and he had a past reaction to the vaccine. At this time, Prevnar 20 was not required, and they would reassess in the future. During an interview, on 9/9/24 at 11:51 a.m., the DON indicated she would check with the resident to see if he still wanted the Prevnar 20 vaccination. A current facility policy, titled Infection Control; Influenza and Pneumococcal Vaccinations, last revised on 7/28/21 and provided by the DON on 9/9/24 at 4:15 p.m., indicated Policy: Essential Senior Health and Living must develop policies and procedures to ensure that all residents in the facility receive the Influenza Vaccination between October 1 thru March 31 annually and the Pneumococcal Vaccination at least once or is either medically contraindicated or has previously been immunized. All residents admitted to the facility will have physician's order for influenza and pneumococcal vaccinations from their physicians, if not current and not medically contraindicated. 3.1-13(a)